AIDS/HIV Infection Policies for Early Childhood and School Settings

Massachusetts Department of Public Health
Massachusetts Department of Education
Massachusetts Board of Education

William F. Weld, Governor
Charles D. Baker, Secretary of Health and Human Services
David H. Mulligan, commissioner of Public Health
Robert V. Antonucci, Commissioner of Education

May 1993

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
150 Tremont Street
Boston 02111

William F. Weld
Governor
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May, 1993

Dear Parents, Educators and Caregivers:

We are pleased to present this volume of AIDS/HIV policies that address the needs of infants, toddlers, preschoolers and school-age students. Over the course of the AIDS/HIV epidemic in Massachusetts, the Department of Public Health, the Massachusetts Board of Education and the Massachusetts Department of Education, working in consultation with health care providers, parents, teachers, administrators and child care specialists have developed these policy statements and informational documents. These policies are based on the most up-to-date medical and legal information currently available.

The Updated Medical Policy Guidelines: Children and Adolescents with HIV Infection/AIDS in School Settings and the Medical Update to Policy Guidelines: Infants, Toddlers and Preschoolers With HIV Infection/AIDS in Early Childhood Settings describe appropriate ways to guarantee the rights of these young people while maintaining the public health. Both policy statements are accompanied by informational materials presented in question and answer formats for parents, educators and caregivers. The Board of Education Policy on AIDS/HIV Prevention Education offers recommendations to local school districts on the development of policies and educational programs that aim to reduce the risk of infection with HIV, the virus that causes AIDS, among students and staff. Included in this policy is an addendum recommending that every Massachusetts school committee consider making condoms available to students in secondary schools. Finally, new guidelines for the handling of medical wastes in a school setting are included.

In addition to this compendium we suggest that you review the Department of Public Health Comprehensive Curriculum Guidelines on HIV/AIDS: Grades K - 12 which were issued in January, 1992. These guidelines recommend content specific to each grade level around AIDS/HIV prevention education and offer annotated resources to assist educators. This publication is available through the State House Bookstore.

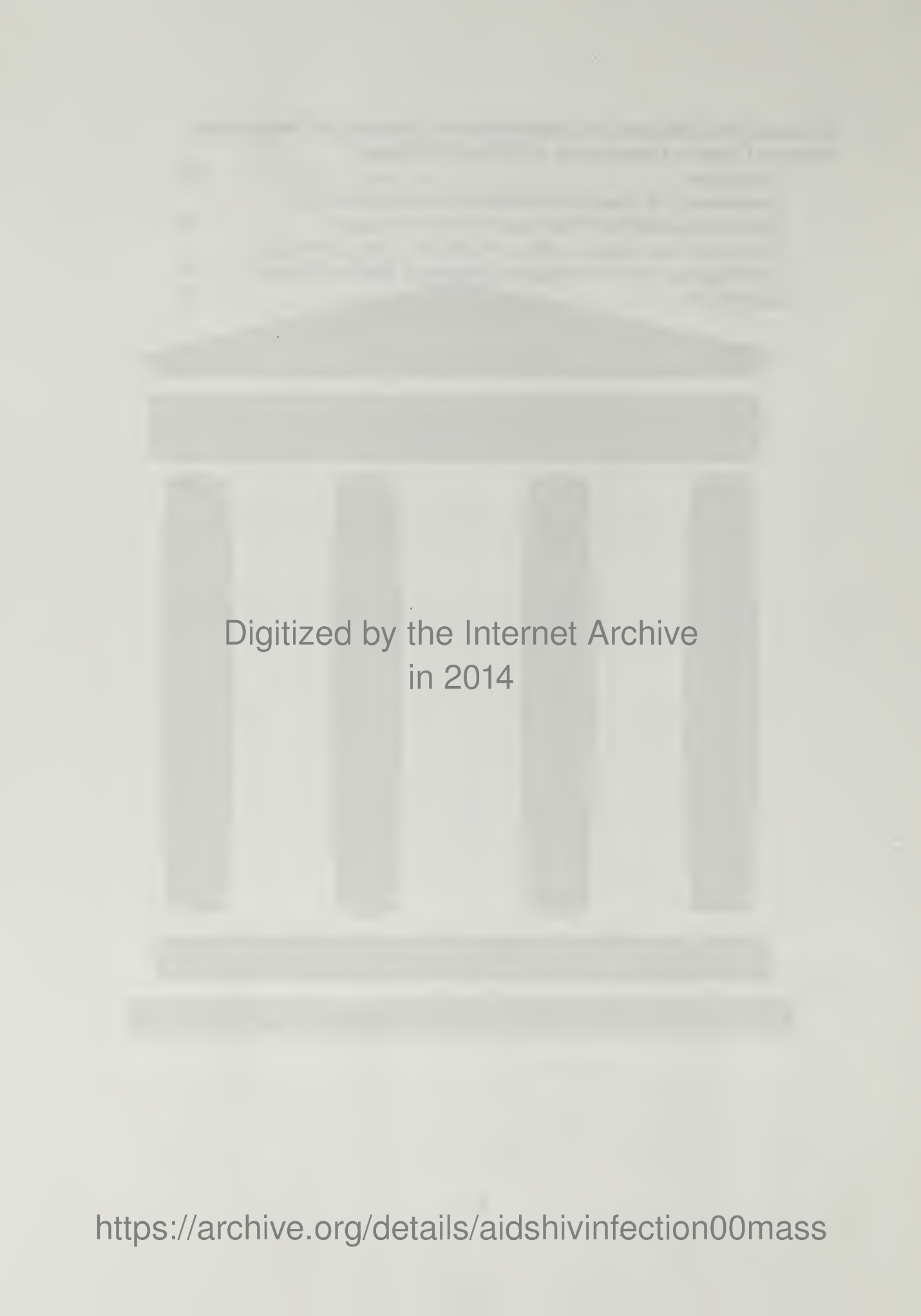
We urge your community to develop approaches to this serious public health problem that are in concert with current medical knowledge, with your local community standards and with the law. These approaches would ideally include local AIDS/HIV policies, a comprehensive health education and human services program, and public discussion of the condom availability issue. Staff at the Department of Public Health AIDS Bureau and Bureau of Family and Community Health and at the Department of Education, Bureau of Student Development and Health are available to provide additional assistance at your request.

Sincerely,

David H. Mulligan
Commissioner of Public Health

Robert V. Antonucci
Commissioner of Education

TABLE OF CONTENTS



Medical Update to Policy Guidelines: Infants, Toddlers and Preschoolers with HIV Infection/AIDS in Early Childhood Settings

MEDICAL UPDATE TO POLICY GUIDELINES
Infants, Toddlers and Preschoolers with HIV Infection/AIDS in Early Childhood Settings

Adopted: October, 1985
Medical Update: June, 1989

In 1985, the Governor's Task Force on AIDS and the Public Health Council recommended guidelines regarding the attendance of HIV-infected children (ages 0-3) in group day care settings. Those guidelines provided for their medical update as more information becomes known about HIV transmission in group settings.

The medically updated recommendations which follow incorporate scientific evidence accumulated since 1985 which demonstrates a lack of HIV transmission between young children in group settings. This update makes our policy consistent with current scientific knowledge as well as with the recommendations of the American Academy of Pediatrics and our own policy for children ages four and over.

These guidelines apply to out-of-home child care including family day care, day care centers, early intervention programs, nursery schools, Head Start programs, public school preschool programs, and respite care providers.

The guidelines for the updated policy follow:

1. Appropriateness of Early Childhood Setting Attendance:

Infants, toddlers and preschoolers with HIV infection/AIDS should be admitted to early childhood settings if their health, neurologic development, and behavior are appropriate. HIV-infected children should be evaluated for attendance at an early childhood setting on a case-by-case basis by the child's parents and the child's physician.

2. Enrollment in a Specific Early Childhood Setting:

As with the enrollment of any child, regardless of HIV status, the parent or guardian and the early childhood program director (or, where there is no director, the primary caregiver) will discuss the appropriateness of the child for the setting. With consent of the parent or guardian, the physician will provide information regarding the child's HIV status.

3. Restrictions:

No child should attend an early childhood setting in the event of:

a) Weeping or bloody skin or mouth sores that cannot be successfully covered or controlled with medications;

b) Biting of an unusual frequency or severity that would be accompanied by actual transfer of blood from the biter, as might happen only from a child with chronically bloody gums or mouth;

c) Bloody diarrhea

These restrictions would hold for <u>any</u> child in an early childhood setting, regardless of his/her HIV status.

4. Continued Attendance:

Continued attendance of an HIV-infected child in an early childhood setting should consider the child's social, psychological, and developmental status; current health status, including degree of immune function and stamina; and the ability of the early childhood caregiver to provide appropriate care. The physician, parent/guardian, and early childhood caregiver will provide ongoing monitoring of the HIV-infected child, including decisions about the child's daily attendance.

5. Medical Information Sharing With Providers:

Information regarding a child who has an immunodeficiency, whatever its cause, should be shared only with the early childhood director and primary direct caregivers who need to know in order to protect the child against other infections. This information, however, doe <u>not</u> require release of a child's HIV antibody status, unless parental consent is given.

6. Confidentiality:

Notifying the early childhood director (or where there is no director, the primary caregiver) of the child's HIV status by the physician requires consent of the parent or guardian. Programs should develop a policy which provides for disclosure to specified primary direct caregivers based on the need to know and parental consent. Notifying parents of other children and other caregivers about the presence of a known or suspected HIV-infected child is unnecessary and prohibited.

7. Medical Records in Early Childhood Settings:

Medical records of all children attending early childhood settings are considered confidential information that must be protected by strict confidentiality provisions. With parental consent, records concerning HIV status may be shared by the director with the primary direct caregivers who need to know in order to protect the child against other infections.

8. Infection Control:

Universal infection control procedures, which are currently in place as outlined in Health in Day Care: A Guide for Day Care Providers in Massachusetts (Massachusetts Department of Public Health, 1988), should be practiced in all early childhood settings. Appendix A presents a summary of these infection control procedures.

9. Screening for HIV Infection:

Screening of children for the presence of HIV antibody prior to enrollment in early childhood care is not warranted or recommended. Decisions regarding HIV antibody testing of a child should be made by the child's physician and parent/guardian, and based on individualized consideration of the child's risk of infection and medical condition.

10. Availability of Consultation

If the child's physician is uncertain about the placement of a specific child in an early childhood setting, or the provider has concerns regarding placement of a child, consultation and assistance with case review are available through the Department of Public Health.

APPENDIX A

INFECTION CONTROL GUIDELINES FOR EARLY CHILDHOOD SETTINGS SERVING INFANTS, TODDLERS AND PRESCHOOLERS

THIS IS A SUMMARY OF THE INFECTION CONTROL PROCEDURES ALREADY IN EFFECT ACROSS THE COMMONWEALTH. Detailed guidelines for managing illnesses are given in Health in Day Care: A Guide for Day Care Providers in Massachusetts published by the Massachusetts Department of Public Health in 1988.

The existing summary guidelines will insure that programs that serve young children protect the health of children and adults in these programs. Infectious diseases can spread easily among young children because they mouth objects as part of their developmental learning process, do not have control of body fluids, and are in close contact with children and adults for long periods of time. These infection control procedures will protect against the spread of all infections, whether they are spread by the respiratory, intestinal, direct contact, or blood-borne routes.

1. General Infection Control Policies:

Infection control procedures should be included as part of comprehensive written health policies. The health policies should include such basics as a system to keep up-to-date medical records that document a child's health examinations, immunizations, and any special health concerns. Such medical records are considered confidential information, and standards for guarding the confidentiality of such information should be part of the program's health policies. Emergency policies and procedures as well as on-going staff training on infection control issues should be included. A health consultant should assist in the development and approval of your program's health policies.

2. Handwashing Guidelines:

HANDWASHING IS THE FIRST LINE OF DEFENSE AGAINST THE SPREAD OF INFECTIONS. Strict handwashing must be practiced by children and staff including, but not limited to, the following times:

* Upon arrival at the program
* BEFORE eating or handling food
* AFTER going to the bathroom or assisting in toileting or diapering
* AFTER contact with body fluid (blood, mucus, feces, vomitus, etc.)
* AFTER cleaning areas contaminated with body fluids
* AFTER handling pets or their equipment

Hands should be washed with running water and liquid soap, using friction for 15-30 seconds. Hands should be dried with disposable towels or a labeled personal towel which is not used by anyone else. The faucet should be turned off with a disposable towel so that clean hands are not dirtied.

3. Sanitization Guidelines:

Commonly used surfaces and toys should be sanitized with a standard bleach solution (solution: small amount = 1 tablespoon household bleach in a quart of water; large amount = 1/4 cup of bleach in a gallon of water). Make the solution fresh daily and keep in a spray bottle out of children's reach. Spray on eating tables, highchairs, countertops, toys, bathrooms, sinks, etc.. Air dry.

4. Diapering Guidelines:

Diapering should be done on a surface used especially for diapering. The surface should be smooth, free of cracks, and non-porous. The surface should be covered by a disposable cover. After each use, throw away the cover, wash any contamination that you can see with soap and water, and spray with the standard bleach solution. The diaper pail should be lined, covered, and preferably have a foot pedal. A sink for handwashing should be directly next to the diapering area. Diapering and food areas should be totally separate from each other. It is not necessary to wear gloves when diapering; it <u>is</u> necessary to wash your hands after diapering, regardless of glove use.

5. Blood Precautions:

You should consider using disposable gloves when contact with large amounts of blood is anticipated, particularly if you have open cuts or scrapes on your hands, or when cleaning surfaces that have been grossly contaminated with blood. Disposable gloves should be available in your first aid kit.

In an emergency, it is <u>not</u> necessary to delay first aid while getting gloves. You should complete emergency first aid using a barrier, such as a towel or your clothing, between you and blood. Wash your hands immediately after giving the required first aid.

If blood has been spilled, you should consider wearing gloves for the clean-up of the bloodied area. Disinfect the affected area with a strong bleach solution of 1 part bleach to 10 parts water. If you wore disposable gloves for the cleaning procedure, remove the gloves and throw them away in a lined, covered container. Whether or not you wore gloves, wash your hands thoroughly with soap and water. Bloody clothing should be sealed in a plastic bag and sent home with the parent for laundering.

6. Personal Items:

Personal items, e.g. eating utensils, toothbrushes, towels and washcloths, bedding, hats, combs, etc., should not be shared. Such items should be stored so that used surfaces are not in contact with other children's personal items.

7. Reporting Illnesses:

Some illnesses should be reported to the local Board of Health. Please refer to the Health in Day Care manual for guidance. If you are unsure, call your local Board of Health, or the Massachusetts Department of Public Health, Division of Communicable Disease Control (617) 522-2700 ext. 420 or Division of Early Childhood (617) 727-5089 for advice.

What is AIDS, and how is AIDS related to HIV infection?

AIDS stands for Acquired Immune Deficiency Syndrome. It is a disease that leaves an individual vulnerable to illnesses that a healthy immune system wards off or overcomes. The symptoms of AIDS includes repeated bouts of infections, usually caused by bacteria, and occurring in different parts of the body. Any one episode of infection may be successfully treated with antibiotics but then another infection typically occurs. Ultimately the child with AIDS is unable to fight off an infection, even with antibiotics, and dies. AIDS is caused by an infection with a virus known as HIV or human immunodeficiency virus. A person may be infected with this virus for a long time (latent period) before they develop AIDS. During this latent period the person may have few, if any, symptoms. Children with HIV infection may be small-for-age long before they develop symptoms of AIDS.

How is the disease detected?

The presence of HIV infection is determined by a blood test. If a person develops symptoms of AIDS, a blood test for the presence of HIV helps confirm the diagnosis. However, many people may be infected with HIV and, during the latent period, not be aware of their HIV infection, though they are capable of transmitting the disease (see below). Therefore there are people (including young children) who have HIV infection but are not aware of it.

Another complication in detecting HIV infection in infants, is due to the fact that the blood test detects antibodies to the virus and not the virus itself. Young infants receive antibodies from their mothers that stay in their bodies for a few months while their own antibodies are gradually taking over. Thus, infants may test positive for the HIV antibodies because they came from their HIV infected mothers, but they do not have the infection themselves. Only about one third of those infants born to mothers with HIV infection will actually turn out to be infected, though all will test positive in the first few months. Thus it may be difficult to accurately detect HIV infection in an infant up to the age of 18 months.

How is the HIV infection transmitted?

In this country the overwhelming majority of young children acquire the HIV infection from their mothers during pregnancy or delivery. Thus, if the infant or young child develops HIV infection, the mother has HIV infection also. However, the mother's infection may also be latent and she may be unaware that she is infected. Or, she may have AIDS. The only way that HIV infection is known to spread from one person to another is: 1) through sexual intercourse; 2) from a mother to her infant during pregnancy or delivery; and 3) from the blood of an infected person entering into the body of an uninfected person. This latter method of transmission most frequently occurs in IV drug users who <u>inject</u> drugs using needles contaminated with blood from other IV drug users. The other common method of transmission through blood <u>was</u> by blood transfusion, donated by infected persons and received by uninfected persons. However, in this country all donate blood has been tested for

HIV infection since 1985, and this mode of transmission is now rare. HIV is spread only by blood or sexual fluids. **HIV is not transmitted through urine, stool (diarrhea), vomitus, saliva (mouthing of toys and other objects), mucus, sweat, or any other body fluid that does not contain blood. HIV is not spread by casual contact.**

How to protect against the spread of HIV infection?

Transmission of HIV infection in the child care setting is only possible through blood from an infected child entering into the body of an uninfected person. This is theoretically (and practically) possible only if the infected child bleeds and others in the child care setting are exposed to that blood through broken skin or mucous membranes (mouth). Therefore, as with Hepatitis B, always treat blood as a potentially dangerous fluid.

- Handle all bleeding wounds with appropriate pressure using a barrier such as thick cloth. Those who wish to be especially cautious, or those with any open sores or cuts, should use disposable gloves (if such use does not endanger the child by delaying treatment).

- It is theoretically possible that a bite by an uninfected child, into an infected child, if the bite draws blood, could result in transmission if blood from the infected child contacts an opening in the mucous membranes of the uninfected child. However, this has never been shown to happen in a child care setting. Such behavior should be controlled by close supervision and by providing children with more acceptable alternatives to express aggressive impulses.

What are recommendations for attendance of children with HIV infection or AIDS?

- **All children with HIV infection or AIDS should be admitted to program as long as their own health and development status allows them to benefit from the program.**

- Remember, no child in the program regardless of known HIV infection, should be attending the program with bloody diarrhea or open, oozing mouth or skin sores that cannot be covered or successfully treated with medication.

- All programs should use appropriate precautions in the handling of all blood spills, since the presence of infection that can be transmitted by blood will not always be known.

- Since known HIV infections is private and privileged information, and since transmission is possible only through blood which all programs must handle appropriately, there is no requirement that the program staff or the families of other children in the program be informed of the HIV

status of a child. However, program directors and health care personnel should be informed of any child who is immunodeficient so that the presence of contagious disease in the program can be communicated immediately to that child's family and doctor. This does not mean that HIV status must be disclosed. There are other causes for immune deficiencies such as being treated for cancer and other immune diseases unrelated to HIV.

Can an adult who is HIV-positive, has HIV infection, or AIDS work in early childhood settings?

Since HIV is not spread by casual contact, there is no reason to exclude the person with AIDS or HIV infection while he/she feels well enough to work. As with any adult in child care, an adult with HIV infection should not work if there are open, oozing sores which cannot be covered until they are healed. Other restrictions are not needed.

Because adults with HIV infection symptoms may be immunocompromised (their immune system is not working well to protect them from illnesses) and may be more likely to get infections. To protect their own health, they should consult their physicians regarding their occupational risk.

Updated Medical Policy Guidelines: Children and Adolescents with HIV Infection/AIDS in School Settings

Updated Medical Policy Guidelines: Children and Adolescents with HIV Infection/AIDS in School Settings

August 1991

Introduction

In the face of the significant public health concerns surrounding Acquired Immune Deficiency Syndrome (AIDS) and infection with the Human Immunodeficiency Virus (HIV), the virus that causes AIDS, schools have played a critical role. Public schools in Massachusetts have coped well with the demands of the AIDS/HIV epidemic by developing quality educational programs that help students reduce their risk of infection, and by maintaining supportive, fair and humane approaches to students with AIDS and HIV infection that protect their rights and their health. We congratulate schools for their efforts to date.

More scientific evidence about the transmission of HIV has become available since publication of the 1986 Massachusetts policy concerning school attendance of children with AIDS/HIV, which was based on the best medical evidence available at the time. Certain behaviors previously suspected of posing a risk of HIV transmission have been ruled out (e.g. most instances of biting, ordinary incontinence). Consequently, this revision brings the policy in line with current knowledge about HIV transmission. With these changes, the policy is consistent with the recommendations of the Medical Update to Massachusetts Policy Guidelines: Infants, Toddlers and Preschoolers with HIV Infection/AIDS in Early Childhood Settings (June, 1989) and the American Academy of Pediatrics Guidelines for Infection Control of Human Immunodeficiency Virus (Acquired Immunodeficiency Virus) in Hospitals, Medical Offices, Schools, and Other Settings (November, 1988). This policy offers recommendations for universal precautions when dealing with blood spills in a school setting. Further, it includes suggested procedures regarding the disclosure within a school of a student's AIDS diagnosis or HIV infection status in keeping with laws regulating the confidentiality of this information.

The fundamental message of the policy remains unchanged:

Students with AIDS/HIV infection have the same right to attend classes or participate in school programs and activities as any other student.

Facts About the Transmission of HIV

HIV can be transmitted through unprotected sexual intercourse, through blood-to-blood contact (such as the sharing of injection drug needles and syringes) and from an infected woman to her baby at or before birth. A large body of research has demonstrated that HIV is **not** transmitted through casual contact, such as in a school setting. Therefore, except in very rare cases (Appendix A), there is no legitimate public health reason to exclude students with AIDS or HIV infection from attending school.

Guidelines for Disclosure

The student's parent(s) or guardian(s)· are the gatekeepers of information relating to the student's AIDS/HIV status. **They are not obliged to disclose this information to school personnel.**

A student who is diagnosed with AIDS or presents evidence of being immuno-compromised is at a greater risk of contracting infections. This means there may be good reasons to inform the school nurse or school physician of a student's AIDS diagnosis or HIV infection status. This student's parent(s) or guardian(s)· would benefit from information from the school nurse or school physician about the occurrence of threatening contagious diseases (such as chicken pox or influenza) when making a decision regarding school attendance. The school nurse or school physician may also need to attend to the particular needs of HIV-infected students regarding immunization schedules and medications.

In consultation with the student's primary care physician, the student's parent(s) or guardian(s)· may decide to inform certain school personnel about the student's AIDS/HIV status, particularly the school nurse or school physician. If they so choose, the following guidelines are recommended:

- The student's parent(s) or guardian(s)· may inform the school nurse or school physician directly.

- Alternatively, the student's parent(s) or guardian(s) may request that their primary care physician make the disclosure. In this case, specific, informed, written consent of the student's parent(s) or guardian(s)· is required.

- **Further disclosure of a student's HIV status by the school nurse or school physician to other school personnel requires the specific, informed, written consent of the student's parent(s) or guardian(s)·.**

Statutes Governing Disclosure

As a general rule, a student's health records related to AIDS/HIV should be regarded as confidential. The Massachusetts General Laws, c.111, s.70F, prohibit health care providers, physicians and health care facilities (including school-based clinics) from disclosing HIV test results, or even the fact that a test has been performed, without the specific, informed, written consent of the person who has been tested. This statute prohibits testing persons for HIV antibodies without their permission, and protects against the nonconsensual release of medical records (including school health records) which contain such information.

These statutory requirements apply specifically to health care providers. However, case law in Massachusetts and other states leads to the conclusion that other school staff members beside health care providers may be liable for civil damages in the event of nonconsensual disclosure of information related to HIV status or AIDS diagnosis. In short, information about an individual's AIDS/HIV status should be treated as highly confidential, and released only with the specific, informed, written consent of the individual's parent(s) or guardian(s).*

Conclusion

School officials, administrators and teachers throughout the Commonwealth have demonstrated their commitment to preserving the rights of students with AIDS/HIV to attend school and participate in school programs and activities, as well as to educate all students in accordance with the Board of Education's Policy on AIDS/HIV Prevention Education (April, 1990). All school staff should be informed about and understand these updated medical guidelines, and should be trained in the observance of universal precautions (see Appendix B). The Departments of Education and Public Health encourage schools to continue their efforts in these areas, and will be pleased to provide resource materials and other guidance as needed. Please call the Massachusetts Department of Education, Bureau of Student Development and Health at (617) 770-7477 for further information.

* Under state public health statute M.G.L. c.112 s.12F minors may consent to their own dental care and medical testing, diagnosis and treatment in certain circumstances (including HIV infection). This law mandates confidentiality of medical information and records except when an attending physician or dentist reasonably believes that the condition of the minor is so serious that the minor's life or limb is endangered. Accordingly, if an adolescent student has sought HIV antibody testing independent of parental consent, that student has the right to keep this information confidential, and any disclosure of this information would require the student's specific, informed, written consent.

Approved August 27, 1991

APPENDIX A

MEDICAL GUIDELINES REGARDING STUDENTS WHO BLEED IN AN UNCONTROLLABLE FASHION IN A SCHOOL SETTING

A number of serious infectious diseases are spread by contact with human blood. Among these blood-borne infections are the Hepatitis B virus and HIV (the virus that causes AIDS). Consequently, students who bleed uncontrollably should not have routine contact with other individuals in school settings.

As a public health measure, students who exhibit the following conditions should be advised not to attend school until such time as these conditions are resolved:

1. if a student has weeping or bloody skin or mouth sores that cannot be successfully covered or controlled with medications

2. if the student exhibits biting of an unusual frequency or severity that would be accompanied by actual transfer of blood from the biter, as might happen only from a student with chronically bloody gums or mouth

3. if the student exhibits bloody diarrhea.

These conditions are grounds for the exclusion of any student from a school setting, regardless of whether she/he is known or suspected to harbor a blood-borne infection.

Adapted from Medical Update to Policy Guidelines: Infants, Toddlers and Preschoolers with HIV Infection/AIDS in Early Childhood Settings (Department of Public Health, June 1989)

APPENDIX B

UNIVERSAL PRECAUTIONS FOR SCHOOL SETTINGS

Universal precautions refer to the usual and ordinary steps **all** school staff need to take in order to reduce their risk of infection with HIV, the virus that causes AIDS, as well as all other blood-borne organisms (such as the Hepatitis B virus).

They are **universal** because they refer to steps that need to be taken in all cases, not only when a staff member or student is known to be HIV-infected.

They are **precautions** because they require foresight and planning, and should be integrated into existing safety guidelines.

Appropriate equipment (mops, buckets, bleach, hot water, hand soap, disposable towels and latex gloves) must be readily available to staff members who are responsible for the clean-up of body fluid spills.

1. Treat human blood spills with caution.

2. Clean up blood spills promptly.

3. Inspect the intactness of skin on all exposed body parts, especially the hands. Cover any and all open cuts or broken skin, or ask another staff member to do the clean-up. Latex gloves contribute an added measure of protection, but are not essential if skin is intact.

4. Clean up blood spills with a solution of one part household bleach to ten parts water, pouring the solution around the periphery of the spill. Disinfect mops, buckets and other cleaning equipment with fresh bleach solution.

5. **Always** wash hands after any contact with body fluids. This should be done immediately in order to avoid contaminating other surfaces or parts of the body (be especially careful not to touch your eyes before washing up.) Soap and water will kill HIV.

6. Clean up other body fluid spills (urine, vomitus, feces), unless grossly blood contaminated, in the usual manner. They do not pose a significant risk of HIV infection.

Adapted from Universal Precautions for School Settings, Massachusetts Department of Education and Medical Update to Massachusetts Policy Guidelines: Infants, Toddlers and Preschoolers with HIV Infection/AIDS in Early Childhood Settings (June, 1989).

UPDATED MEDICAL POLICY GUIDELINES:

CHILDREN AND ADOLESCENTS WITH HIV INFECTION/AIDS

IN SCHOOL SETTINGS

QUESTIONS AND ANSWERS

Massachusetts Department of Education
Bureau of Student Development and Health

Introduction

On August 27, 1991, the Massachusetts Board of Education approved Updated Medical Policy Guidelines: Children and Adolescents with HIV Infection/AIDS in School Settings. These updated guidelines, which were jointly developed by the Massachusetts Department of Education and Department of Public Health, reflect the most current information available about AIDS and HIV infection and are in keeping with state law regarding the confidentiality of medical information.

The following questions and answers are designed to assist school administrators, school health care providers, teachers and other school staff develop local policies and procedures that implement the guidelines, and are designed to help parents, guardians and students make informed decisions about how and when to disclose medical information regarding a student's AIDS diagnosis or HIV infection.

At the end of this document you will find resources that may be of further help to you as you deal with these important issues. The Departments of Education and Public Health will continue to be available to assist you in the implementation of the Updated Medical Policy Guidelines.

1. What are AIDS and HIV Infection?

AIDS (Acquired Immune Deficiency Syndrome) is a serious, often fatal disease of the immune system. The immune system is the body's defense against the many organisms that inhabit our environment. It protects us from bacteria, fungi, viruses and other living things that cause disease.

When a person is diagnosed with AIDS, their immune system no long functions properly, rendering the person susceptible to serious conditions that ordinarily do not affect healthy individuals. AIDS is caused by infection with a virus called HIV (the Human Immunodeficiency Virus). A person can be infected with HIV a long time (ten years or more) without showing symptoms. Over time, HIV destroys T helper cells, important components of the immune system, causing it to work less and less efficiently. After a period of time, many persons with HIV begin having relatively common symptoms such as fatigue, frequent fevers and swollen "glands". A person is defined as having AIDS when they develop more serious and rarer conditions such as certain forms of pneumonia, particular cancers, significant weight loss and other possibly life-threatening conditions.

2. How do people get AIDS and HIV infection?

In order to get AIDS, HIV must get into a person's body. HIV is transmitted from one person to another through one of the following behaviors: blood-to-blood contact (such as sharing drug injection needles or getting a transfusion with infected blood products), through sexual intercourse (including unprotected anal, vaginal or oral intercourse) and from an infected woman to her baby at or before birth (and in rare cases through breast feeding). HIV is <u>not</u> transmitted through casual contact such as hugging, kissing, holding hands, eating or drinking from the same dishes or sitting in a room with someone with HIV. This has been demonstrated by extensive studies of families with HIV infected members. HIV has never been transmitted in these families, despite their close contact, except when members had engaged in one of the risk behaviors listed above.

3. How many school-age children and adolescents in Massachusetts have AIDS or HIV infection?

In Massachusetts as many as 400 young children and 1,500 adolescents have contracted HIV. A much smaller number of children and adolescents in Massachusetts (fewer than 200) have been diagnosed with AIDS, but because of the lengthy period a person can be infected with HIV and not have symptoms, the number of AIDS diagnoses is not the best indicator of the scope of the epidemic in young people.

4. How many AIDS diagnosed or HIV infected children and adolescents are enrolled in Massachusetts public schools?

We do not know how many children there are in our public schools, but we are certain that many schools across the Commonwealth have students who are AIDS diagnosed or HIV infected. The epidemic is growing, and we are only at the beginning of a trend toward more and more diagnosed or infected students enrolled in public schools. It is likely that every school system in the Commonwealth will eventually have an HIV infected student.

5. Why is it necessary to issue updated medical policy guidelines?

The existing policy regarding students with AIDS or with signs of HIV infection was based on the best medical evidence available at the time (September, 1986). While generally supporting the rights of these students to attend school, it took a cautious stance regarding students displaying certain behaviors and conditions, such as biting, frequent incontinence and open sores, and recommended that these students be excluded from attending school. The U.S. Centers for Disease Control and the American Academy of Pediatrics have since updated their recommendations to schools, and the updated medical policy guidelines reflect the findings of these authorities.

The updated guidelines state that except in a very rare set of situations where a student chronically bleeds uncontrollably*, a student with AIDS or HIV infection poses no risk of transmission of HIV infection through the kind of casual contact which occurs in a school setting. Therefore a student with AIDS or HIV infection has the same right to attend school and participate in school programs as any other student.

In addition, a similar update to the policy guidelines regarding early childhood settings was issued in 1989 by the Massachusetts Department of Public Health. The two sets of policy guidelines dealing with young children and with school-age students now make consistent recommendations.

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*Any student who regularly bleeds uncontrollably puts other persons at risk for contracting one of a number of infections that are blood-borne (especially the Hepatitis B virus). Therefore, Appendix A of the updated medical guidelines recommends that these students be restricted from attending school until their medical conditions are resolved.

6. According to the updated policy guidelines, who needs to know of a student's AIDS diagnosis or HIV infection?

No one except the student and/or the student's parent(s) or guardian(s) necessarily need to know this information. Like any medical information, a diagnosis of AIDS or a positive test for HIV antibodies is confidential. Since persons with AIDS or HIV infection pose no public health threat to others by their presence, there is no reason to treat their medical information as anything but private.

On the other hand, it might serve the medical interests of a student with AIDS or HIV infection to inform the school nurse or school physician of their health status. For example, a young person with AIDS or HIV infection might be taking medications that should be administered by a health care professional, or they may need different immunizations (vaccines) than other students. Schools are bound by state law to manage certain medications taken in school and to determine whether a student has had certain immunizations. Knowledge of the AIDS diagnosis or HIV infection of a student might help the school nurse or school physician do their job better.

Students with AIDS and some students with HIV infection are more likely to catch infections from other students or from school staff. If there is an occurrence of a contagious disease in school such as chicken pox or influenza, the school nurse or physician might be able to warn the students' parent(s) or guardian(s), who may want to consult their personal care physician for preventive treatment or a recommendation to keep their child at home.

7. Can staff in the school be told of a student's AIDS diagnosis or HIV infection?

If there has been disclosure to school personnel, other staff may be told only if the student's parent(s) or guardian(s) give their permission in writing. The general state privacy law (Massachusetts General Laws chapter 214, section 1B) protects against unwarranted invasion of privacy, and a state law specifically governing HIV antibody tests (M.G.L. C.111, s.70F) requires the consent of a person or their legal guardian(s) before disclosing information about the fact that a test has been performed or the results of that test.

A student and the student's parent(s) or guardian(s) may want to inform, for example, the student's teacher(s), counselor, school principal or other staff members, but they are not obliged to so. This is <u>their</u> decision alone.

8. Should AIDS/HIV related medical information be placed into the student health record?

As a general rule, no. Student health records are routinely accessible to multiple school staff. Licensed physicians, nurses, social workers and psychologists (according to M.G.L. C.111 s.70F as well as C.112 s.135A and C.112 s.129A) have a duty to protect AIDS/HIV related and other private information and, therefore, should not place such information into the student's health record. Given the privacy protections of C.214 s.1B, other school personnel are under a similar duty to protect the confidentiality of the information. Again, because of its accessibility by multiple school staff, specific, informed, written consent should be obtained from the student's parent(s) or guardian(s) prior to entering this information into the school health record.

9. Can school staff be held liable for violating these laws?

Yes. If a health care provider (such as the school nurse or school physician) or a health care facility discloses a student's HIV antibody test result without specific, informed, written consent, that provider or facility violates state law (M.G.L. C.111 s.70F) and possibly faces a civil suit brought by the student or the student's parent(s) or guardian(s). Other school staff may be held liable for violating the privacy of an AIDS diagnosed or HIV infected student under the general privacy law and likewise are open to being sued by the student or the student's family.

10. How should a student's parent(s) or guardian(s) make disclosure of the student's AIDS diagnosis or HIV infection?

In order to maximize confidentiality, it is best to tell only the school nurse or physician. The most confidential way to make this disclosure is verbally and face-to-face. The student's parent(s) or guardian(s) may do this themselves, or they might want to enlist the help of their personal care physician. Even the personal care physician needs to have the specific, informed, written consent of the student's parent(s) or guardian(s) before discussing this with school staff.

If and when informed, written consent is given to enable school staff to disclose to others in the school, the form or letter giving this consent should spell out specifically who should be told. Specify the <u>names</u> of individuals, not their roles in the school (i.e. principal, homeroom teacher, guidance counselor), because these staff positions may change, and the student's family might not want the new person holding the position to be informed.

11. If disclosure has been made to other school personnel, are they constrained in any way from sharing this information?

M.G.L. C.214 s.1B prohibits the unwarranted invasion of a person's privacy. Therefore, all school staff are well advised to refrain from discussing AIDS/HIV related information regarding a student without specific, informed, written consent.

12. How should written information about the AIDS diagnosis or HIV infection of a student be kept in a school setting?

Sometimes school nurses and school physicians need to have access to strictly medical information in order to carry out their professional responsibilities (for example when a student's personal care physician has given detailed instructions on the administration of medications). These private medical notes should be kept in a locked file separate from the school health record and should only be accessible to staff who have been given written consent to view them. Likewise, school psychologists, social workers and other professionals may keep private notes of their sessions with students. If these notes contain information about a student's AIDS diagnosis or HIV infection, they should similarly be kept in a locked file.

A school which has signed informed consent forms related to AIDS diagnosis or HIV infection should keep these documents in a separate, locked file as well. You may want to place the consent form in a file. It is recommended that the consent form be enclosed in a folder that specifically states who has permission to read it, since the consent form itself contains sensitive information.

13. Do these recommendations apply to other personal information?

Yes, school physicians, nurses, social workers and psychologists are bound by the privacy statute (M.G.L.C.214. s.1B) to prevent the unwarranted disclosure of other sensitive information (for example regarding a student's infection with a sexually transmitted disease, pregnancy, terminal disease, abuse history) besides AIDS/HIV. This information may also be kept in a locked file.

14. Do all students with AIDS or HIV infection know of their condition?

No. Some parents of young children choose not to tell them the exact nature of their condition. Others prefer to be more open or to tell their children when they think it appropriate. In many cases older students are quite aware of their status as HIV infected or AIDS diagnosed. In some families, the child is not the only HIV infected member, and the issues surrounding disclosure are complex. School staff should take their cues from the parent(s) or guardian(s) regarding whether to discuss a student's AIDS diagnosis or HIV infection with the student.

15. Are there students who are the only ones to know of their HIV infection?

Yes. Under the state public health statute (M.G.L. C.112 s.12F) minors may consent to their own dental care and medical testing, diagnosis and treatment in certain circumstances (including HIV infection). This law mandates confidentiality of medical information and records except when an attending physician or dentist reasonably believes that the condition of the minor is so serious that the minor's life or limb is endangered.

A growing number of adolescents are choosing to exercise this right and be tested for HIV antibodies. Some of these young persons also choose not to inform their parent(s) or guardian(s) of their test results. In this case, if an HIV infected student informs a member of the school staff, that school staff person must be sure not to violate the student's right to keep this information confidential. Any disclosure of this information requires the student's specific, informed, written consent, unless there is an immediate threat of serious harm to the student. Given that parents have the right to inspect certain school records, staff who have been informed by a student of her/his HIV infection must take care not to put this information into any school record that may be seen by parent(s), guardian(s) or other persons that the student chooses not to inform. Parent(s) and guardian(s) do not have access to private medical or mental health notes.

16. What sorts of questions might school staff want to ask parent(s) or guardian(s) about AIDS diagnosed or HIV infected students?

While most students with HIV infection and AIDS behave and function perfectly normally in school, in order to perform their professional duties better, school staff may want to know more about the student's personal issues and special needs such as:

- Does the student know about her/his condition?
- Do the student's siblings and friends know about her/his condition?
- What sorts of medical problems has the student experienced?
- Is the student likely to miss much class due to illness?
- Will the student need tutoring or other academic support?
- Has the student experienced neurological problems/developmental delays?
- Are the student and the family getting adequate social support?
- Do the student and her/his family have access to adequate health care?

SAMPLE INFORMED CONSENT FORM

I, _____,

the parent/guardian of _____
(or the name of student in the case of a consenting adolescent minor)

hereby give my consent for the disclosure of the following medical information:

(check as many as apply)

___ HIV antibody test result

___ AIDS diagnosis

___ summarized medical record

___ details of symptoms, signs and diagnostic test results (specify_____)

___ psychiatric, other mental health and/or developmental evaluation records (specify_____)

___ names of medical care and/or support service providers (specify_____)

___ probable mode of HIV infection (specify_____)

___ infection status of other family members (this will require the informed consent of each family member or the parent(s)/guardian(s) of the family member)

to name(s)_____,

role(s)_____

for the express purpose of _____.

This release is limited to a single disclosure of the above listed information to the above named individuals. Any disclosure of information not listed above or to individuals not listed above is expressly prohibited. Disclosure to any other persons than those listed above requires my informed, written consent. This release expires one year from the date it is signed.

Signature_____

Date_____

RESOURCES

For further information about the Updated Medical Policy Guidelines and to request training or consultation call:

AIDS/HIV Program
Massachusetts Department of Education
Bureau of Student Development and Health
1385 Hancock Street
Quincy, MA 02169
(617) 770-7477

For further information about immunizations and the preventive treatment of certain infectious diseases in a student with a suppressed immune system contact:

Your personal care physician, or the

Immunization Program
Massachusetts Department of Public Health
State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130
(617) 522-3700 x420

Readings dealing with school policies, student support services, HIV antibody testing and infection control:

Someone At School Has AIDS: A Guide to Developing Policies for Students and School Staff Members Who are Infected with HIV
Katherine Fraser
National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000
$10.50, postage paid

Guidelines for HIV and AIDS Student Support Services
published by:
National Coalition of Advocates for Students
100 Boylston Street, Suite 737
Boston, MA 02116
$4.00, postage paid

Adolescent HIV Counseling and Testing Policy
Massachusetts Department of Public Health
AIDS Office
150 Tremont Street
Boston, MA 02111
(617) 727-0368
free

"Education of Children with Human Immunodeficiency Virus Infection" Pediatrics, Vol.88, No.3, September 1991.

"Pediatric Guidelines for Infection Control of Human Immunodeficiency Virus (Acquired Immunodeficiency Virus) in Hospitals, Medical Offices, Schools, and Other Settings" Pediatrics, Vol.82, No.5, November 1988.

Board of Education
Policy on AIDS/HIV Prevention Education

The Commonwealth of Massachusetts
BOARD OF EDUCATION
1385 Hancock Street, Quincy, Mass. 02169

POLICY ON AIDS/HIV PREVENTION EDUCATION

AIDS (acquired immune deficiency syndrome) and infection with HIV (human immunodeficiency virus), the virus that causes AIDS, are serious threats to the lives and health of young people in Massachusetts. HIV is transmitted through unprotected sexual intercourse and through blood-to-blood contact, such as that which occurs when intravenous needles are shared.

Due to prevalent patterns of sexual activity and substance abuse, many of our young people are at significant risk of infection with HIV. Our schools must play a major role in the concerted effort to stop the spread of the virus by helping students make healthy choices about their personal behaviors.

Further, as the number of individuals infected with HIV or diagnosed with AIDS continues to grow, we need to come to terms with these members of our local communities. Schools must also play a part in assisting students develop informed and compassionate responses towards those affected by AIDS/HIV.

Therefore, the Board of Education of the Commonwealth of Massachusetts urges local school districts to create programs which make instruction about AIDS/HIV available to every Massachusetts student at every grade level. These programs should be developed in a manner which respects local control over education and involves parents and representatives of the community.

The Board believes that AIDS/HIV prevention education is most effective when integrated into a comprehensive health education and human services program. Ideally, content related to various aspects of the AIDS/HIV epidemic (biological, social/historical, ethical, behavioral, interpersonal, statistical) will be spread across several curriculum areas, especially science, social studies, health, home economics, language arts and mathematics.

Current state law (General Laws Chapter 71, section 1) requires all schools to offer instruction in health education, including such topics as community health, body structure and function, safety and emotional development. We urge all school districts to develop with input from parents and community members, and to include as part of a comprehensive health education and human services program, an AIDS/HIV program which takes into consideration the following components of a complete AIDS/HIV prevention education program:

- **policy** - Appropriate local policies should be adopted regarding AIDS/HIV prevention education as well as the continued attendance of students and employment of staff who are HIV infected. Parents and representatives of the local community should be actively involved in the development and approval of these policies.

- **parent and community education** - The Board strongly suggests that schools play a leadership role in developing educational programs on AIDS/HIV for parents and community members who may reinforce the prevention message presented in the classroom.

- **staff development** - The Board believes that staff training is an essential component of an effective AIDS/HIV education program. In addition to faculty training, staff education should be directed to all school staff and should include basic information about AIDS/HIV, instruction in the use of recommended universal precautions when dealing with blood spills and training regarding relevant policies dealing with HIV-infected students and staff.

- **curriculum and instruction** - This instruction should be offered at all grade levels (including special education classes, programs, schools and residential facilities) in a developmentally, linguistically and culturally sensitive manner. Special efforts should be made to educate hard-to-reach and high-risk young people, particularly youth who are out of school, are drug-involved, are gay/bisexual or are members of communities disproportionately affected by the AIDS/HIV epidemic.

  Instruction in AIDS/HIV prevention should occur over multiple sessions, in a format which maximizes student interaction. This instruction should respect students' various learning styles. It should increase students' knowledge about AIDS/HIV, allow students to process their feelings about the AIDS/HIV prevention and should encourage the development of positive self-esteem and concrete decision-making, communication and behavioral skills.

  At the secondary level, and according to local decisions, AIDS/HIV education should be part of a more complete sexuality education curriculum. This curriculum should include information about sexually transmitted diseases and the value of both sexual abstinence and the use of condoms as disease prevention methods.

  The Board recommends that, when possible, persons living with AIDS/HIV be utilized in the classroom to impress upon students the reality of the epidemic and to build compassion and respect for persons affected by AIDS/HIV.

- **student involvement** - Students should be actively involved in AIDS/HIV educational efforts. Peer education programs and student-initiated projects are especially encouraged in order to develop a sense of students' responsibility for their own behaviors and for community members who are living with AIDS/HIV.

Approved April 24, 1990

ADDENDUM TO AIDS/HIV PREVENTION EDUCATION POLICY REGARDING CONDOM AVAILABILITY IN SCHOOLS

Due to the rising rate of HIV infection and other sexually transmitted diseases among adolescents, the need to address infection prevention in all ways possible is critical at this time. In Massachusetts, decisions about AIDS/HIV prevention education and sexuality education, like all decisions about curriculum and educational policy, are made at the school district level. In response, a number of school systems in Massachusetts have recently begun to consider making condoms available to students in secondary schools.

The Massachusetts Board of Education's Policy on AIDS/HIV Prevention Education states that AIDS/HIV prevention education should include information about sexually transmitted diseases, as well as the value of both sexual abstinence and the use of condoms as disease prevention methods. As school districts consider condom availability at the secondary level, the Board of Education makes the following recommendations as an addendum to the AIDS/HIV Prevention Education Policy:

We recommend that every school committee, in consultation with superintendents, administrators, faculty, parents and students consider making condoms available in their secondary schools.

We recommend that school districts consider varied routes through which students may acquire condoms, including the offices of school nurses and counselors as well as coin-operated vending machines located in men's and women's rooms. The school nurse or counselor's office would place condom availability in the context of a one-to-one professional relationship that could supplement the prevention education offered in the classroom. The vending machines would provide access to condoms in a manner that maximizes students' privacy and anonymity.

We recommend that school districts consider whether students at the secondary level need instruction about the correct use of condoms in order to increase understanding and effect behavior change.

Finally, we recommend that parent information accompany any efforts to make condoms available to students in schools. Parents would then be able to reinforce AIDS/HIV prevention messages at home, and place these messages in the context of their own personal values and religious traditions.

Addendum approved August 27, 1991

Advisory on Disposal of Infectious or Physically Dangerous Medical Waste Generated in School Settings

Massachusetts Department of Public Health
Bureau of Family and Community Health
School Health Unit

Advisory on Disposal of Infectious or Physically Dangerous Medical Waste Generated in School Settings

December 1992

The purpose of this advisory is to clarify the responsibilities of schools for the disposal of infectious or physically dangerous medical waste. In Massachusetts this waste is regulated by 105 CMR 480.000: Storage and Disposal of Infectious or Physically Dangerous Medical or Biological Waste, State Sanitary Code, Chapter VIII.

These regulations define (1) what is infectious and physically dangerous medical waste, (2) who is a generator of such waste, and (3) how infectious and physically dangerous medical waste must be handled.

This advisory deals only with those categories of infectious or physically dangerous medical waste which normally would be expected to be found in a school setting. In those circumstances where a waste is within the categories noted in Section I below, the procedures for disinfection and disposal provided in Sections II and III must be followed.

I. **Categories**:

A major but not controlling consideration for the inclusion of an article as an infectious or physically dangerous medical waste is that the article had been used for a medical purpose. There may be some exceptions such as culture plates and human blood used in the classroom for demonstration and experimentation purposes.

Examples of infectious or physically dangerous medical waste which may be found in school settings include:

A. **Sharps**: Discarded medical articles such as needles, syringes, scalpel blades, razor blades, lancets, broken medical glassware and pasteur pipettes.

B. **Blood and Blood Products**: Includes discarded bulk human blood and blood products in a free-draining liquid state, body fluids contaminated with visible blood and **materials saturated and dripping with blood**.

C. **Cultures and Stocks of Infectious Agents and Associated Biologicals**: All discarded live and attenuated vaccines intended for human use and all discarded culture plates that may have been used for demonstration in science classes. (See attached regulations for complete definitions.)

Please note:

1. While it is unlikely that biological effluent, stocks of infectious agents or contaminated animal carcasses may be encountered

in a school setting, the enclosed regulations define the above and apply to their disposal.

2. Band-aids and other dressings are included in the definition of infectious or physically dangerous medical waste only if they are saturated and dripping with blood. It should be noted that band-aids/dressings which are not saturated with blood, as well as articles that are used for personal hygiene such as sanitary napkins or tampons, should be handled with care and caution but may be disposed of as regular solid waste.

3. While the non-medical use of sharps excludes the need to handle and dispose of these articles in accordance with the regulations, care must be taken to dispose of them in a safe manner to prevent cuts and puncture wounds.

II. Procedures for Handling Infectious and Physically Dangerous Medical Wastes in School Settings:

Follow Universal Precautions. This is an infection control concept in which all human blood and certain body fluids are treated as if they are infectious for bloodborne pathogens. Always wear latex gloves while handling infectious or physically dangerous medical waste.

A. **Sharps**: Sharps must be segregated from other waste and aggregated in leak proof, rigid, puncture-resistant, shatter proof containers immediately after use. Do not recap or break needles from syringes before placing in containers. These containers must be red, distinctively marked with the biohazard symbol and labeled to indicate that they contain sharp waste capable of inflicting punctures or cuts. Both containers and biohazard labels are available through medical supply houses.

B. **Free-draining Blood and Blood Products**: Free-draining blood and blood products shall be stored at all times in leak proof containers that are sealed. Unless restricted by the local sewer department or the local board of health, these wastes may be disposed into a sanitary sewage system.

C. **Medical Waste Spills**: Clean up blood spills with a 1:10 household bleach (sodium hypochlorite) solution prepared within twenty-four hours before use, pouring the solution around the periphery of the spill and onto the spill itself. When a bleach solution may not be used (as on a carpet) use a chemical disinfectant which is EPA (Environmental Protection Agency) registered as indicated on the label. Follow the manufacturer's instructions for appropriate use and dilution.

D. **Other Categories of Infectious Waste**: Other categories of infectious waste which may be found in a school setting and not described in Section II A-C must be placed in double non-permeable 3 mil or equivalent polyethylene bags. The bags must be securely sealed to eliminate leaks. These bags must be red and marked with the biohazard symbol.

Note: Small amounts of infectious and physically dangerous medical waste may be disinfected by saturation with a 1:10 household bleach (sodium

hypochlorite) solution. Bleach solution should be fresh (prepared within twenty-four hours before use). Place treated waste in double bags, (polyethylene bags or 3 mil non-permeable), which should not be red, for disposal with the regular trash. Mark "DISINFECTED MEDICAL WASTE" and the name of the school.

III. Procedures for Removal from the School and Disposal of Infectious and Physically Dangerous Medical Waste.

A. Disposal of infectious and physically dangerous medical waste may be accomplished by various means including chemical, steam, or thermal disinfection or by incineration. **Sharps, if treated by any method other than incineration must be rendered physically non-hazardous by grinding prior to ultimate disposal.** Incineration must occur in a Type IV incinerator which has been approved by the Massachusetts Department of Environmental Protection. (Consult the MDEP for further information.)

B. The school's responsibilities include:

1. The preparation of the infectious and physically dangerous medical waste in an acceptable manner; (See Section II.)

2a. The provision of contractual arrangements for the ultimate disposal of waste which is not disinfected on-site at the school. This may be accomplished through a waste disposal company capable of handling infectious waste or by agreement through a visiting nurse agency, hospital or physician's office or other agency;

OR

2b. In the case of infectious or physically dangerous medical waste which is disinfected and disposed of on-site, a log must be kept in a bound book with the date and signature of the individual who disinfected the waste. (Example: "Date: Bloody dressing disinfected by bleach solution.") The waste then should be double-bagged and disposed of with the general waste.

NOTE: The removal of infectious or physically dangerous medical waste from any site of generation, including schools, requires that the generator prepare a manifest* which tracks the waste from the point of generation through the point of ultimate disinfection and disposal. It is also important that the school district ensure that the waste is being transported to an appropriate facility for disinfection and disposal. Consult the regulations for specific regulations relative to this process and an example of a manifest.

Biohazard symbol labels, red bags, and red containers for disposal of sharps are available through medical supply houses.

References:

1. 105 CMR 480.000 Massachusetts State Sanitary Code Chapter VIII: Storage and Disposal of Infected or Physically Dangerous Medical or Biological Waste. Department of Public Health, August 1989.

2. "Updated Medical Policy Guidelines: Children and Adolescents with HIV Infection/AIDS in School Settings." Commonwealth of Massachusetts, Board of Education, August 1991.

3. "Recommendations for Prevention of HIV Transmission in Health-Care Settings," Morbidity and Mortality Weekly Report Supplement. U.S. Centers for Disease Control, 1987; 36:9S-12S.

4. Occupational Safety and Health Administration (OSHA): "Occupational Exposure to Bloodborne Pathogens; Final Rule", 6 December 1991; 56:64176-64182.

* Under state public health statute M.G.L. c.112 s.12F adolescents may, without parental consent, access testing, diagnosis and treatment for certain dangerous diseases that pose a threat to the public health (including HIV infection). Accordingly, if a student is age 13 or over and has sought HIV antibody testing without parental consent, that student has the right to keep this information confidential, and any disclosure of this information would require the student's specific, informed, written consent. This student may choose to make disclosure to selected school staff according to the procedures outlined in this policy. In this case, no action should be taken on the part of school staff that may compromise her/his confidentiality.